

U. S. Department of the Interior (DOI) – Medical Practitioner’s Certification Application for Disabled Parking

The employee completes section 1. Please have your health care provider complete section 2 and sign.

Privacy Act Statement: Federal Property Management Regulations, Section 101-20.104, Parking Facilities, authorizes the collection of all information which will be used by the DOI Parking Office and the medical practitioners at the DOI health unit to determine your eligibility for a parking space. Failure to provide the information requested on the form may result in denial of a parking permit.

Section 1: for Employee

Your name: _____ Bureau/Office: _____

Work Phone: _____ Cell phone or Home Phone: _____

1. I authorize the medical practitioners at the DOI Stewart Lee Udall building’s Health Unit to receive medical records and to discuss my medical condition with the care provider indicated in section 2. I understand that the information collected and discussed is to be treated confidentially and that only directly relevant information may be shared with the DOI Parking Office and my bureau/office.

_____(signature) Date: _____

Section 2: for Employee’s Health Care Provider

1. Does the above named individual have a severe impairment which for all practical purposes precludes the use of public transportation? _____ Yes _____ No

a. If yes, please explain in detail the medical basis for any conclusion that the above named individual is unable to use public transportation or participate in ride sharing (e.g. metro access). Include your diagnosis, diagnosis code and how it limits this employee’s mobility. If you require additional space, please attach a separate sheet.

Respond here:

2. What aids to mobility does the individual use, such as a wheelchair, walker, crutches, cane, electric cart, prosthesis or walking cast?

3. How many stairs can the individual safely ascend and/or descend?

___ no stairs ___ 6 stairs or less ___ 6-12 stairs ___ 12 stairs or more

4. How far can the individual walk from his/her car to their office without causing danger to themselves?

___ 10 – 80 yards ___ 150 yards ___ 300 + yards, escalator

5. What is the expected duration of this disability:

Short term? ___ less than 3 months ___ 3-6 months *

Long term? ___ more than 6 months ___ 6 months to 1 year ___ permanent

* 5 a. If the expected duration of the disability is greater than 3 months, please explain why:

6. Will there be an expected change in the individual’s condition over the next year (e.g., surgery ?)

Employee's name (from page 1) _____

Section 2, continued: for Employee's Health Care Provider

Based on the above, I certify that this individual's disability is so severe that it precludes the use of public transportation or participating in ridesharing or Metro Access.

Physician's name: (Print) _____

Signature: _____

Date: _____

Telephone: _____

Practice address:

Thank-you for providing this information! You may fax this 2 page form directly to the private fax at the DOI Health Unit, Attention: Barbara Hayden at 202 – 208 - 7175

This section for DOI Health Unit Medical Practitioner's communication to the DOI parking office :

Disabled parking Assignment approved: Yes { } No { }

Duration of parking assignment approved: Permanent { } Temporary { } duration _____

Parking Location:

Main Interior Building [] South Interior Building [] Federal Reserve Building []

Signature and title: _____

Date: _____

Comments: